How did you hear about us? (please circle one) Reviewed by Provider: _____
Family/Friend Internet Signage/Advertising Other: _____ Scanned/Entered by: _____

HEALTH QUESTIONNAIRE

The purpose of this questionnaire is to ensure that your electronic medical record contains complete and up-to-date information so we can provide you with optimal comprehensive care. Please fill in the relevant sections to the best of your ability and give to your health care provider at your next visit. Strict confidentiality is ensured. Thank you.

Name (Last, First, M.I.):			**DOB:**
Previous Family Physician:			**Last Seen:**
Current Address:			
City		**Postal Code**	
Email		**Phone:**	

CURRENT MEDICAL HISTORY

List Current Conditions (please use back of page if you need more room)

Physical:	
Emotional & Social:	

List details of your prescription medications below (if unable to list, bring them with you to our clinic)

Prescription Medications – Name	Strength	Frequency Taken

List your non-prescription medications (over-the-counter drugs, vitamins, herbs, etc.)

List the details of allergies or side effects to medications below (Medications or Food) including Reaction

PAST MEDICAL HISTORY

Childhood Illness: Have you ever had **chickenpox**? ☐ Yes ☐ No*

Immunizations: (include dates)	☐ **Tetanus** within past 10 years	☐ **Pneumonia**
	☐ **Chickenpox***	☐ **Hepatitis** (circle type): A B Both Unsure

Type of Operation or Procedure	Reason	Year

Major Past Problems/Injuries	Outcome	Year

Obstetrical History/ Complications: (indicate number if any)

Total Pregnancies:	**Term Deliveries:**	**Preterm Deliveries:**
Miscarriages:	**Pregnancy Terminations:**	**Living:**

Patient Name: _____ DOB: _____

FAMILY MEDICAL HISTORY	
Please indicate relationship and approx. age of onset for blood relatives with any of the following conditions	
Disease	**Relationship & Approximate Age of Onset**
Heart Disease	
High Cholesterol	
Diabetes	
Asthma	
Stroke	
Dementia/Alzheimer's	
Osteoporosis	
Psychiatric Problem	
Cancer (indicate type)	

SOCIAL HISTORY						
Marital Status:	☐ Never Married	☐ Married	☐ Common Law	☐ Separated	☐Divorced	☐ Widowed
Occupation:		☐ Student	☐ Retired	☐ Disability	☐ Social Assistance	
Recreation/Hobbies:						
Religion:						
Lifestyle	**Circle what best describes your diet:**	VERY POOR	POOR	FAIR	GOOD	EXCELLENT
	Circle what best describes your activity level:	MINIMAL	POOR	FAIR	GOOD	EXCELLENT
Tobacco	**Circle your smoking status:**	NEVER SMOKED	SMOKER	EX-SMOKER	PASSIVE SMOKE CONTACT	
	Cigarettes - #/day:			**Year Stopped:**		
Alcohol	**Circle what best describes your drinking habits:**	NONE	LIGHT	MODERATE	HEAVY	EX-DRINKER
	How many drinks per day on average:			**Year Stopped:**		
	Are you concerned about the amount you drink?				☐ Yes	☐ No
	Have you considered cutting down?				☐ Yes	☐ No
	Are you prone to "binge" drinking?				☐ Yes	☐ No
	Have you ever had a problem with alcohol?				☐ Yes	☐ No
Street Drugs	**Circle what best describes your recreational drug use:**	NEVER	EX-USER	LIGHT	MODERATE	HEAVY
	If yes, have you ever given yourself street drugs with a needle?				☐ Yes	☐ No
	What drugs have you used?					
	How often do you usually use?			**Date last used?**		
Sex	**Have you ever had sex?**				☐ Yes	☐ No
	Are you sexually active now?				☐ Yes	☐ No
	If yes, what contraceptive method do you use, if any?					
	Do you have any problems with infertility?				☐ Yes	☐ No
	Circle your sexual orientation:	HETEROSEXUAL	BISEXUAL	HOMOSEXUAL	UNKNOWN	

PREVENTION AND WELLNESS	
Preventive Screening Tests (please give approximate dates for the following)	
Women Only	(<70) **Date of last pap** (recommended every 1-2 years):
	(>50) **Date of last mammogram** (recommended every 1-2 years):
Both	(>50) **Date of last stool test for colon cancer** (recommended once a year):
	Date of last cholesterol test:
Personal Health Goals	
What areas of your life would you like to make changes in?	
What changes have you made/are you making so far?	
What help would you like?	